U.S. Department of Labor

Office of Administrative Law Judges
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Issue Date: 09 March 2007

CASE NO.: 2005-BLA-05965

In the Matter of

V.M., Surviving spouse of
H.M.
Claimant

v.

J & D COAL COMPANY
Employer

and

KENTUCKY COAL PRODUCERS
SELF-INSURANCE FUND
Carrier

and

DIRECTOR, OFFICE OF WORKERS'
COMPENSATION PROGRAMS
Party-in-Interest

Appearances: EDMOND COLLETT, Esq.
For the Claimant

RODNEY E. BUTTERMORE, JR., Esq.
For the Employer

CHRISTIAN P. BARBER, Esq.
For the Director, Office of Workers' Compensation Programs,
U.S. Department of Labor

Before: ADELE HIGGINS ODEGARD
Administrative Law Judge

DECISION AND ORDER DENYING SURVIVOR'S BENEFITS

This proceeding arises from a claim for benefits under the Black Lung Benefits Act, 30 U.S.C. §§ 901-945 ("the Act") and the regulations issued thereunder, which are found in Title 20 of the Code of Federal Regulations. Regulations referred to herein are contained in that Title.

Benefits under the Act are awarded to coal miners who are totally disabled within the meaning of the Act due to pneumoconiosis acquired while working in the Nation's coal mines, or to the survivors of coal miners whose death was due to such pneumoconiosis. Pneumoconiosis, commonly known as black lung, is a disease of the lungs that may result from coal dust inhalation.

On June 1, 2005, this case was referred to the Office of Administrative Law Judges for a formal hearing. Subsequently, the case was assigned to me. The hearing was held before me in Harlan, Kentucky on August 22, 2006, at which time the parties had full opportunity to present evidence and argument.

The decision that follows is based upon an analysis of the record, the arguments of the parties, and the applicable law.

I. ISSUES

The following issues are presented for adjudication:

1) Whether the Employer is properly designated as the Responsible Operator;
2) Whether the Miner suffered from pneumoconiosis;
3) Whether the Miner's pneumoconiosis arose out of coal mine employment; and
4) Whether the Miner died due to pneumoconiosis.

II. PROCEDURAL BACKGROUND

The Claimant filed this claim for benefits on August 12, 2004 (DX 3).[1] On March 21, 2005, the District Director issued a proposed Decision and Order granting benefits to the Claimant, based on a determination that the Claimant established the conditions for entitlement to benefits (DX 34). The Employer timely requested a formal hearing (DX 35), and the matter was referred to the Office of Administrative Law Judges for hearing (DX 42).

III. FINDINGS OF FACT AND CONCLUSIONS OF LAW

[1] The following abbreviations are used in this Opinion: "DX" refers to Director's Exhibits; "CX" refers to Claimant's Exhibits; "EX" refers to Employer's Exhibits; "T" refers to the transcript of the August 22, 2006 hearing.

A. Factual Background

The Claimant is the widow of a Miner who died in April 1998 at the age of 50 (DX 3, 15). The record also reflects that the Miner applied for Federal black lung benefits in 1991. His claim was administratively denied in January 1992 (DX 1). At the hearing, the parties stipulated that the Miner had 11 years of coal mine employment (T. at 17-18). The Claimant's claim, which enclosed a copy of the Work History Form (CM-911a) the Miner had submitted with his own claim, asserted that the Miner's coal mine employment ended in May 1990 (DX 9).

According to records maintained by the Social Security Administration, the Miner was employed by the Employer from 1983 to 1989 (DX 10, 11). However, the record also contains the Miner's W-2 (tax withholding) forms, dated 1989 and 1990, reflecting his employment with the "High Rise Coal Co., Inc., P.O. Box 359, Cawood, KY 40815" (DX 9). Additionally, the record contains a copy of the Miner's signed statement, dated May 1991, that he was employed by High Rise Coal Company for approximately nine months, ending on May 28, 1990; this statement was made in response to an inquiry the District Director made during the adjudication of the Miner's claim for benefits (DX 8).

B. Claimant's Testimony

The Claimant testified under oath at the hearing. She stated that she and the Miner were married in 1974, and that he died in April 1998. They have one son, who is now an adult. The Claimant testified that she and her husband had been married for about five years before he became a miner, and she believed that he worked as a miner until about five years before his death. The Claimant stated that her husband worked mostly underground; he started out outside and then moved inside. She testified that her husband would come home from the mines with coal dust on his hands, face and clothing (T. at 19-20).

The Claimant testified that toward the end of his life, her husband was on a breathing pill, a nebulizer, and an inhaler. These were prescribed by Dr. Rachel Eubank, his primary care physician. The Claimant stated that her husband was a smoker and smoked until his death. She also testified that he coughed up phlegm; coughed or wheezed at night; used more than one pillow when he slept; and was short winded. The Claimant related that her husband, who had lung cancer, died in the hospital, the morning after he had been admitted (T. at 21-24).

On cross-examination, the Claimant testified that her husband was under the care of Dr. Wiler (sic) when he died, and had been diagnosed with lung cancer about six months before. She also stated that he received workers' compensation for about two years, possibly for his lung condition, and that he received Social Security disability payments as well. The Claimant also testified that her husband smoked two packs of cigarettes a day up to his death. Regarding her husband's medical treatment, the Claimant stated that he had 44 radiation treatments and two "chemo" treatments. He was scheduled for more "chemo," but he died (T. at 25-32).

In response to my questions regarding the cause of the Miner's death, the Claimant stated that he "smothered to death," from respiratory failure. She stated that she took him to the hospital twice, the week before he died, to have fluid removed from his lungs, and then they

returned home. According to the Claimant's testimony, his doctors intended that the Miner would continue treatment. However, the last time she brought him to the hospital, she was told that he would not be able to recover from the crisis, and he died (T. at 33-36).

At the hearing, the Claimant initially stated that the Employer was the last employer for whom her husband worked; then she recalled that he worked for High Rise Coal Company for about a year (T. at 26-27; T. at 32; T. at 36).

The record also contains the transcript of the Claimant's deposition and the Claimant's responses to the Employer's interrogatories, dated January 2005 (DX 25; DX 22). In her deposition, the Claimant stated that Dr. Eubank was her husband's physician for about five years before his death. She summarized her husband's coal mine employment, testifying that he ran a drill in an underground mine when he worked for the Employer. The Claimant confirmed that her husband worked for High Rise, and stopped working because of his breathing problems. She also stated that Dr. Eubank referred the Miner to other physicians in Louisville, but she could not recall their names. The Claimant testified that Dr. Eubank was present when her husband died, and reiterated that her husband was under treatment for his breathing problems, and had been prescribed oxygen and nebulizers, before he was diagnosed with cancer (DX 25).

In her responses to the Employer's interrogatories, the Claimant stated that her husband first encountered breathing problems about 10 years before his death, and saw Dr. Eubank for his breathing. The Claimant also stated that her husband was "unable to do much of anything due to his breathing problems" (DX 22 at 6).

C. Designation of the Responsible Operator

Section 725.495 states that the operator responsible for the payment of benefits shall be the potentially liable operator that most recently employed the miner. The designation of "responsible operator" is thereby limited to those entities which may be designated as "potentially liable operators." A "potentially liable operator" must have been an operator for any period after June 1973 (§725.494(b)); must have employed the miner for a cumulative period of not less than one year (§725.494(c)); must have employed the miner for at least one day after December 1969 (§725.494(d)); and must be capable of assuming financial liability for the payment of benefits (§725.494(e)). The latter condition is established if the operator had insurance for the time period covering the miner's employment; if the operator qualified as a self-insurer and still has sufficient assets to self-insure or secure the payment of benefits; or if the operator possesses sufficient assets to secure the payment of benefits.

During the administrative processing of the current claim, the District Director determined that the Employer was the last operator to have employed the Miner for a period of one year or more (DX 27). The Employer controverted its designation as Responsible Operator during the administrative processing of this matter, but has not provided any evidence to contradict the District Director's determination that the Employer was the last operator to have employed the Miner for the requisite time period (See DX 29, 31, 35).

The regulation states that the designated responsible operator shall bear the burden of proving either that it does not possess sufficient assets to secure the payment of benefits, or that it is not the potentially liable operator that most recently employed the miner. In the latter circumstance, the designated responsible operator must also establish that the later employer possesses sufficient assets to secure the payment of benefits. §725.495(c).

In this case, the record reflects that the Miner was employed by High Rise Coal Company after his employment with the Employer. The record, specifically, the Miner's W-2 forms, establishes that the Miner was employed by High Rise Coal Company in 1989 and 1990. However, the record does not establish that this company employed the Miner for an aggregate of one year or more, as is necessary for it to be designated as a potentially liable operator under §725.494. The evidence regarding the length of the Miner's employment with that company consists of the Miner's 1991 statement, which indicates that he worked for High Rise for approximately nine months (DX 8), and the Claimant's testimony at the hearing that the Miner worked for High Rise for "about a year" (T. at 36). From my observation of her demeanor at the hearing, I find that the Claimant is generally credible in her testimony; however, I also find that her statement regarding her husband's employment for "about a year" for High Rise does not establish that he worked for that company for one year or more. In addition, I find that the Miner's written statement, executed approximately one year after he ceased his employment, is more reliable than the Claimant's recollection, more than 15 years after the fact. Moreover, even assuming arguendo that the Employer did establish that High Rise employed the Miner for a full year, the Employer has failed to establish that High Rise is sufficiently sound financially to assume responsibility to pay benefits.

Based on the foregoing, I find that the Employer has failed to establish that it was improperly designated the responsible operator, as is required pursuant to §725.495. Consequently, I find that the Employer is properly designated as the responsible operator in this case.

D. Relevant Medical Evidence

The Claimant submitted, in her affirmative case, interpretations of the Miner's February 26, 1991, chest X-ray, by Dr. J.M. Harrison, and his July 12, 1991, chest X-ray, by Dr. L.G. Thorley (DX 26). The Claimant also submitted the Miner's death certificate, signed by Dr. Rachel Eubank, which stated that the Miner died due to respiratory failure and "adenocarcinoma of the lung with metastes," and that "pneumoconioses" was a contributing cause (DX 15) along with a written statement from Dr. Eubank, dated May 2004 (DX 18).

In addition, the Claimant submitted approximately 100 pages of medical treatment records from Harlan Appalachian Regional Health (ARH), covering the period from 1985 to 1998; most of these records are from 1997 and 1998, and they include treatment notes regarding the Claimant's final hospitalization and his death (DX 19).

The Employer submitted a medical report of Dr. Abdul Dahhan, dated December 2004, supplemented by an amended report dated June 2006 (DX 20; EX 2), as well as Dr. Dahhan's deposition testimony, from July 2006 (EX 1). In addition, the Employer submitted a medical

report from Dr. Gregory Fino, dated January 2005 (DX 21). Lastly, the Employer submitted approximately 15 pages of medical treatment records, pertaining to the Miner's hospitalization at Holston Valley Medical Center, in Kingsport, Tennessee, in March 1998 (EX 3).

These items will be discussed in greater detail below.

E. Evidentiary Issues

At the hearing, the Employer objected to the admission of the two X-ray interpretations the Claimant had submitted, based on the Employer's determination that the originals of the two X-ray films at issue were no longer available for review (T. at 10-11). The Claimant requested the opportunity to attempt to locate the films (T. at 10-12). I ordered that the record be held open for 90 days, so that the two films could be located and the Employer provided the opportunity to have the films interpreted. I also informed the parties to advise me if the films had been destroyed or were otherwise unavailable (T. at 14-16).

No party submitted any items of evidence after the hearing. On January 5, 2007, the Employer submitted a Motion for Extension of Time to Submit Briefs. In my Order granting the Employer's Motion, I noted that no party had submitted any post-hearing evidence, and I had received no information regarding the X-ray films. Therefore, I presumed that the films were not available, and I directed the parties to address the issue of the admissibility of the X-ray films in their closing briefs.

The Employer's post-hearing brief, filed on January 25, 2007, states: "The films have still not been found and apparently no longer exist" (Employer's Brief at 3). The Director's brief, filed on December 28, 2006, states that the films are "no longer available" (Director's Brief at 3). The Claimant's brief, dated February 14, 2007, states that the films are "unavailable for rereading" (Claimant's Brief at 3).

The governing regulation, at §725.414, sets forth limitations on the quantum of evidence that may be received. In general, each party is permitted to submit, in its affirmative case, up to two interpretations of a miner's chest X-ray. In survivor's claim cases, the medical evidence from the prior living miner's claim must have been designated as evidence by one of the parties in order for it to be included in the record relevant to the survivor's claim. Church v. Kentland-Elkhorn Coal Corp., BRB Nos. 04-0617 BLA and 04-0617 BLA-A (April 8, 2005); see also 20 C.F.R. 725.414(a)(3)(i). In general, an X-ray interpretation may be considered only if the original film is available to the other parties for review. However, where the chest X-ray of a deceased miner has been lost, destroyed, or is otherwise unavailable, a report of a chest X-ray submitted by any party shall be considered. §718.102(d).

In this case, the Claimant requested that two X-ray interpretations, presumably from the Miner's claim, be considered as evidence in the instant case (DX 26). I granted the parties time to search for the X-ray films; however, apparently the films cannot be located. I am satisfied that the films of the Miner's February 26, 1991 and July 12, 1991 X-rays are unavailable. Therefore, as authorized under §718.102(d), the X-ray interpretations of Dr. Harrison and Dr. Thorley are admissible as evidence, and I will consider them.

F. Entitlement

The Act provides for benefits to eligible survivors of deceased miners whose death was due to pneumoconiosis. §718.205(a). Eligible claimants may include a miner's widowed spouse. §725.201(a)(2). Under §718.205, where there is no miner's claim filed prior to January 1, 1982 resulting in entitlement to benefits, a survivor who files a claim after January 1, 1982, as in this case, is entitled to benefits only upon demonstrating that the Miner died due to pneumoconiosis.

In a survivor's claim, it must first be determined whether the miner suffered from coal workers' pneumoconiosis before a finding may be made regarding the etiology of his death. Trumbo v. Reading Anthracite Co.,17 B.L.R. 1-85 (1993). In order to establish entitlement to benefits in a survivor's claim filed on or after January 1, 1982, therefore, a claimant must establish three elements by a preponderance of the evidence: (1) that the miner had pneumoconiosis; (2) that the miner's pneumoconiosis arose out of coal mine employment; and (3) that the miner's death was due to pneumoconiosis. §718.205(a)(1) through (3). Trumbo v. Reading Anthracite Co., 17 B.L.R. 1-85 (1993). The Claimant has the burden to establish each element of entitlement. Director, OWCP v. Greenwich Collieries, 512 U.S. 267 (1994).

1. Whether the Miner had Pneumoconiosis

a. Pneumoconiosis Defined:

Section 718.201(a) defines pneumoconiosis as "a chronic dust disease of the lung and its sequelae, including respiratory and pulmonary impairments, arising out of coal mine employment." This definition includes both medical or "clinical" pneumoconiosis, and statutory, or "legal" pneumoconiosis, which themselves are defined in that subparagraph at (1) and (2). "Clinical" pneumoconiosis consists of diseases recognized by the medical community as pneumoconioses, characterized by permanent deposition of substantial amounts of particulates in the lungs, and the fibrotic reaction of the lung tissue, caused by dust exposure in coal mine employment. "Legal" pneumoconiosis includes any chronic lung disease or impairment and its sequelae arising out of coal mine employment. Further, §718.201(b) states: "a disease 'arising out of coal mine employment' includes any chronic pulmonary disease or respiratory or pulmonary impairment significantly related to, or substantially aggravated by, dust exposure in coal mine employment."

b. Establishing the Existence of Pneumoconiosis

There are four means of establishing the existence of pneumoconiosis, set forth at §§718.202(a)(1) through (a)(4):

(1) X-ray evidence: §718.202(a)(1).
(2) Biopsy or autopsy evidence: §718.202(a)(2).

(3) Regulatory presumptions: §718.202(a)(3).[2]
(4) Physician opinion based upon objective medical evidence: §718.202(a)(4).

X-ray Evidence

Section 718.202(a)(1) states that a chest X-ray conducted and classified in accordance with §718.102 may form the basis for a finding of the existence of pneumoconiosis. ILO Classifications 1, 2, 3 A, B, or C shall establish the existence of pneumoconiosis; Category 0, including subcategories 0/0 and 0/1, do not establish pneumoconiosis.

The current record contains the following chest X-ray evidence:[3]

Date of X-Ray	Date Read	Ex.No.	Physician	Radiological Credentials[4]	Interpretation
02/26/1991	02/26/1991	DX 26	Harrison	B reader[5]	ILO: 1/1 (6 zones)
07/12/1991	08/07/1991	DX 26	Thorley	BCR, B reader[6]	ILO: 1/1 (6 zones)

[2] These are as follows: (a) an irrebutable presumption of total disability due to pneumoconiosis if there is evidence of complicated pneumoconiosis (§718.304); (b) where the claim was filed before January 1, 1982, there is a rebuttable presumption of total disability due to pneumoconiosis if the miner has proven fifteen (15) years of coal mine employment and there is other evidence demonstrating the existence of totally disabling respiratory or pulmonary impairment (§718.305); or (c) a rebuttable presumption of entitlement applicable to cases where the miner died on or before March 1, 1978 and was employed in one or more coal mines prior to June 30, 1971 (§718.306).

[3] Medical treatment records at DX 19 and EX 3 contain narrative reports of multiple chest X-rays. Because it is not clear whether these X-rays interpreted for the presence of pneumoconiosis, they are not included in the chart below. I note, however, that several X-rays included in the medical records mention that the Miner exhibited changes consistent with chronic obstructive pulmonary disease ("COPD").

[4] A physician who is a Board-certified radiologist ("BCR") has received certification in radiology of diagnostic roentgenology by the American Board of Radiology, Inc., or the American Osteopathic Board of Radiology. See generally: http://www.answers.com/topic/radiology #after_ad1. A B reader is a physician who has demonstrated proficiency in assessing and classifying X-ray evidence of pneumoconiosis by successful completion of an examination conducted by the National Institute for Occupational Safety and Health (NIOSH). NIOSH is a part of the Centers for Disease Control and Prevention, in the U.S. Department of Health and Human Services. See 42 C.F.R. §37.51 for a general description of the B reader program.

[5] Dr. Harrison's qualification as a B reader is noted on the X-ray interpretation form (DX 26 at 2). His professional credentials are not otherwise included in the record.

[6] Dr. Thorley's qualifications as a Board-certified radiologist and B reader are noted on the X-ray interpretation form (DX 26 at 3). His professional credentials are not otherwise included in the record.

It is well established that the interpretation of an X-ray by a B reader may be given additional weight by the fact-finder. Aimone v. Morrison Knudson Co., 8 B.L.R. 1-32, 34 (1985). The Benefits Review Board has also held that the interpretation of an X-ray by a physician who is a Board-certified radiologist as well as a B reader may be given more weight than that of a physician who is only a B reader. Scheckler v. Clinchfield Coal Co., 7 B.L.R. 1-128, 131 (1984). Additionally, a finder of fact is not required to accord greater weight to the most recent X-ray evidence of record. Rather, the length of time between the X-ray studies and the qualifications of the interpreting physicians are factors to consider. McMath v. Director, OWCP, 12 B.L.R. 1-6 (1988); Pruitt v. Director, OWCP, 7 B.L.R. 1-544 (1984).

Discussion

In this case, both X-ray interpretations submitted in conjunction with the Claimant's claim concluded that the Miner had pneumoconiosis. These interpretations are of different X-rays, taken approximately five months apart. I note that the record reflects that Dr. Harrison, a B reader, and Dr. Thorley, a Board-certified radiologist and B reader, were consistent in their interpretations that the Miner had pneumoconiosis.

Apparently, as the parties discussed in their post-hearing briefs, the original X-ray films are no longer available; additional interpretations of these X-rays are therefore impossible to obtain. Under the governing regulation, however, X-rays of a deceased miner "shall be considered" on the issue of whether the miner had pneumoconiosis, notwithstanding the fact that the original films are no longer available for review. §718.102(d).

Notably, in this case the only X-ray evidence before me is positive for the existence of pneumoconiosis. Consequently, I find that the evidence establishes, through X-ray, that the Miner had pneumoconiosis.

Biopsy or Autopsy Evidence

A determination that pneumoconiosis is present may be based on a biopsy or autopsy. §718.202(a)(2). That method is not available here, as the current record contains no such evidence.

Regulatory Presumptions

A determination of the existence of pneumoconiosis may also be made using the presumptions described in §§718.304, 718.305, and 718.306. Section 718.304 requires X-ray, biopsy, or equivalent evidence of complicated pneumoconiosis, which is not present in this case. Section 718.305 is not applicable because this claim was filed after January 1, 1982. §718.305(e). Section 718.306 applies only in cases of deceased miners who died before March 1, 1978. Since none of these presumptions applies in this case, the existence of pneumoconiosis has not been established under §718.202(a)(3).

Physician Opinion

The fourth way to establish the existence of pneumoconiosis under §718.202 is set forth in subparagraph (a)(4): A determination of the existence of pneumoconiosis may also be made if a physician exercising sound medical judgment, notwithstanding a negative X-ray, finds that the miner suffers or suffered from pneumoconiosis as defined in §718.201. Any such finding shall be based on objective medical evidence such as blood gas studies, electrocardiograms, pulmonary function studies, physical performance tests, physical examination, and medical and work histories. Such a finding shall be supported by a reasoned medical opinion. As stated above, the definition in §718.204(a) of pneumoconiosis includes both medical, or "clinical" pneumoconiosis and statutory, or "legal" pneumoconiosis, and so a physician opinion may be expected to discuss either "clinical" pneumoconiosis, or "legal" pneumoconiosis, or both.

A medical opinion is reasoned if the underlying documentation and data are adequate to support the findings of the physician. Fields v. Island Creek Coal Co., 10 B.L.R. 1-19 (1987). A medical opinion that is unreasoned or undocumented may be given little or no weight. Clark v. Karst-Robbins Coal Co., 12 B.L.R. 1-149 (1989). Generally, a medical opinion is well documented if it provides the clinical findings, observations, facts and other data the physician relied on to make a diagnosis. Fields, supra. An opinion based on a physical examination, symptoms, and a patient's work and social histories may be found to be adequately documented. Hoffman v. B. & G Construction Co., 8 B.L.R. 1-65 (1985).

The record contains the following physician opinions:

Dr. Rachel Eubank (DX 15, 18)

As the Claimant testified at the hearing, Dr. Eubank was the Miner's treating physician for several years prior to his death, and she signed the Miner's death certificate. As noted above, the death certificate lists "respiratory failure" and "adenocarcinoma of lung with metastates" as the causes of the Miner's death, and cites "pneumoconioses" as a significantly contributing factor (DX 15). Dr. Eubank's opinion is on the letterhead of the Clover Fork Clinic, located in Evarts, Kentucky, and is dated May 2004. In its entirety, Dr. Eubank's opinion is as follows: "[The Miner] had Black Lung first diagnosed at our clinic on 4-10-91. He had adenocarcinoma of the lung diagnosed on 9/97. He died of respiratory failure on 4-11-98. It is my opinion the Black Lung contributed to his early demise with respiratory failure" (DX 18).

Dr. Abdul Dahhan (DX 20; EX 1, 2)

At the request of the Employer, Dr. Dahhan, who is Board-certified in internal medicine and pulmonary medicine and is a B reader, reviewed medical records pertaining to the Miner and submitted a written report in December 2004 (DX 20). The records Dr. Dahhan reviewed included the Miner's death certificate; Dr. Eubank's opinion, set forth above; and treatment notes, discharge summaries, and medical test records (including X-rays) from Harlan ARH.

In his report, Dr. Dahhan concluded that the Miner developed "opacification of the left lung, secondary to fluid with pneumonia in the right lung, with the combination resulting in

respiratory failure" and that this caused the Miner's death. He commented that the Miner's cancer and its complications, including the Miner's death, were not caused by, aggravated or hastened by the inhalation of coal dust or coal workers' pneumoconiosis. Dr. Dahhan also concluded that there was no data to support Dr. Eubank's statement that the Miner had pneumoconiosis. Dr. Dahhan concluded that the medical evidence he reviewed was insufficient to justify the diagnosis of coal workers' pneumoconiosis or other occupationally acquired lung disease. He also concluded that the Miner's lung cancer and pneumonia, which led to his death, were not caused by or related to the Miner's coal mine employment (DX 20).

Dr. Dahhan's second medical opinion, dated June 2006, reflects a review of additional documents, including the two chest X-rays discussed above, Dr. Fino's report, and additional medical records (including many not otherwise included in the record). In this opinion, Dr. Dahhan concluded that there was "no evidence to justify the diagnosis of coal workers' pneumoconiosis as documented by the negative chest X-rays and CT readings for that disease, as well as the normal arterial blood gases and pulmonary function studies prior to his development of lung cancer" (EX 2 at 3). Noting that the Miner was a heavy smoker (1 ½ to 2 packs per day for 25 years), Dr. Dahhan also concluded that there was no evidence that coal dust exposure or pneumoconiosis caused, contributed to, aggravated or hastened the Miner's lung cancer or death, and stated that the medical literature does not establish that pneumoconiosis causes or contributes to the development of lung cancer (EX 2).

Dr. Dahhan also testified by deposition, in July 2006 (EX 1). In his deposition, Dr. Dahhan testified that the Miner died due to complications from his lung cancer. Dr. Dahhan related that the Miner's hospitalization records indicted that the Miner was hospitalized due to fluid buildup in both lungs, as a result of the malignancy. This caused the Miner to be extremely short of breath with a severe drop in his oxygen. The Miner's family requested that no aggressive measures be taken because his condition was terminal, and he died. Dr. Dahhan explained that fluid in the lungs interferes with the transfer of oxygen (EX 1).

Dr. Gregory Fino (DX 21)

At the request of the Employer, Dr. Fino, who is Board-certified in internal medicine and pulmonary disease and is a B reader, examined medical records relating to the Miner, dating back to 1994, and submitted a written report in January 2005. Dr. Fino concluded that the Miner did not have coal workers' pneumoconiosis, and noted that there was no evidence of any pre-existing lung disease before the Miner's cancer diagnosis. Specifically, Dr. Fino noted that there were no chest X-ray readings positive for pneumoconiosis. Although Dr. Fino discussed arterial blood gas readings showing that the Miner had hypoxemia, he stated that these readings coincided with the development of the Miner's lung cancer and were most probably due to that cause.

Dr. Fino also concluded that there was no evidence to support Dr. Eubank's opinion that black lung disease contributed to the Miner's death, and stated that the Miner died due to an aggressive form of lung cancer. Citing multiple medical journal articles, Dr. Fino concluded that there is no established link between coal dust exposure and lung cancer, and opined that the Miner's lung cancer was due to his smoking (DX 21).

Medical Treatment Records (DX 19; EX 3)

As noted above, the parties submitted medical treatment records from Harlan ARH (DX 19) and Holston Valley Medical Center in Kingsport, Tennessee (EX 3). Except for one page of records from 1985 involving a muscle strain, the medical treatment records from Harlan ARH cover the time period between 1994 and the Miner's death. The vast majority of the records cover the Miner's treatment for his lung cancer. The records from Holston Valley Medical Center cover several days in March 1998, and discuss the Miner's hospitalization and treatment at that facility, after he had been diagnosed with lung cancer. Portions of the records reflect that the Miner may have been diagnosed with coal workers' pneumoconiosis in the past, but otherwise the records do not discuss that condition.[7]

Discussion

Dr. Eubank's opinion provides only a conclusion – that her clinic diagnosed the Miner with pneumoconiosis. She provides no supporting evidence for that conclusion; nor does she refer to any medical procedures or tests that led her to that conclusion. Under the regulation, a physician opinion must be "reasoned" and based upon "objective medical evidence." §718.202(a)4). Because Dr. Eubank failed to cite any medical evidence, I cannot credit her opinion as "reasoned." Consequently, I give her opinion no weight.[8]

Dr. Dahhan's opinion, that the Miner did not have pneumoconiosis, is based at least in part on his assessment of several X-ray interpretations (at least eight) which are not in the record. As §725.414(a)(3)(i) instructs, any X-ray interpretations that appear in a medical report must be admissible under that section, either as medical treatment records or as affirmative or rebuttal evidence. Consequently, I must disregard that portion of Dr. Dahhan's conclusion based on X-ray interpretations, as the evidence upon which it is based is not properly a matter of record.[9] The remainder of Dr. Dahhan's conclusion is based on his assessment that the Miner had normal pulmonary function and arterial blood gas test results, prior to his lung cancer diagnosis. As the regulation recognizes, pulmonary function and arterial blood gas tests measure lung impairment. They are not intended as diagnostic tests for pneumoconiosis. See §718.204. Because this portion of Dr. Dahhan's conclusion is not based on objective medical tests that could diagnose pneumoconiosis, I find that it is not well-reasoned, and I give it no weight.

Dr. Fino's medical opinion is based on a review of medical records that span the time period between 1994 and 1998. The records that he reviewed consisted of the Miner's medical treatment records, the death certificate, and Dr. Eubank's medical opinion. His conclusion that

[7] See, e.g., DX 19 at 55, 85, 87.

[8] I recognize that Dr. Eubank was the Miner's treating physician. However, the record provides no information, other than the length of her treatment of the Miner, to suggest her opinion should be given controlling weight. See §718.104(d). See also Eastover Mining Co. v. Williams, 338 F.3d 501 (6th Cir. 2003).

[9] In addition, I note that the majority of the X-ray interpretations Dr. Dahhan cites to support his conclusion that the Miner did not have pneumoconiosis in fact seem to be positive for the disease (EX 2 at 2-3).

the Miner did not have any evidence of respiratory disease (or impairment) prior to his lung cancer diagnosis is accurate, based on the records that he reviewed. However, the records Dr. Fino reviewed are incomplete. For example, Dr. Fino did not review the two X-ray interpretations from 1991, by Dr. Harrison and Dr. Thorley, discussed above. Given the medical evidence Dr. Fino reviewed, I find no error in his reasoning; however, I find his opinion not to be well-reasoned, because it is based on an incomplete picture of the Miner's respiratory medical history. Therefore, I give it no weight.

Based on the foregoing, therefore, I find that the record contains there is no well-reasoned medical opinion on whether the Miner had pneumoconiosis, and I decline to give any weight to any of the medical opinions presented. I find, therefore, that the Claimant is unable to establish, by means of physician opinion, that the Miner had pneumoconiosis.

Taking the evidence as a whole, I find that the only evidence of pneumoconiosis, as defined in the regulation, consists of the two X-ray interpretations listed above. In the absence of any credible evidence to the contrary, I find that these X-ray interpretations are sufficient to establish that the Miner had pneumoconiosis. I find, therefore, that the Claimant has established, by a preponderance of evidence, that the Miner had pneumoconiosis.

2. Whether the Pneumoconiosis "Arose out of" Coal Mine Employment

Under the governing regulation, a miner who was employed for at least ten years in coal mine employment is entitled to a rebuttable presumption that pneumoconiosis arose out of coal mine employment. §718.203(b). The parties have stipulated that the Miner had 11 years of coal mine employment. I find that the record supports this stipulation.[10] Consequently, the Claimant is entitled to rely on the rebuttable presumption. The Employer has proffered no evidence to rebut the presumption.

Therefore, I find that the Claimant has established, by a preponderance of evidence that the Miner's pneumoconiosis arose from his coal mine employment.

3. Whether the Miner's Death was Due to Pneumoconiosis

For claims filed on or after January 1, 1982, §718.205(c) provides the criteria for determining whether a miner's death is due to pneumoconiosis. This section requires that the Claimant establish one of the following:

(1) competent medical evidence establishes that pneumoconiosis was the cause of the miner's death;

(2) pneumoconiosis was a substantially contributing cause or factor leading to the miner's death, or death was caused by complications of pneumoconiosis; or

[10] The Miner's Social Security records indicate that the Miner was employed by coal mine operators for at least a portion of each of the following years: 1968, 1971-1975; 1981; 1983-1989 (DX 11).

(3) where the presumption set out at §718.304 [complicated pneumoconiosis] applies. Trumbo v. Reading Anthracite Co., 17 BLR 1-85 (1993); Neely v. Director, OWCP, 11 BLR 1-85 (1988); Boyd v. Director, OWCP, 11 BLR 1-39 (1988).

In this case, there is no evidence that the Miner had complicated pneumoconiosis, as set forth in §718.304. Consequently, the Claimant bears the burden to establish that the Miner's death was due to pneumoconiosis or complications of the disease, or that pneumoconiosis was a substantially contributing cause of the Miner's death. The regulation provides that pneumoconiosis is a "substantially contributing cause" of a miner's death if it "hastens the miner's death." §718.205(c)(5). The regulation also cautions, however, that survivors are not eligible for benefits where the miner's death was caused by a traumatic injury or the principal cause of death was a medical condition not related to pneumoconiosis, unless the evidence also establishes that pneumoconiosis was a substantially contributing cause of death. §718.205(c)(4).

In addition to the Miner's death certificate and the medical opinions discussed above, the record contains the following evidence relating to the circumstances of the Miner's death.

Medical Treatment records from Harlan ARH (DX 19)

These 105 pages of records include approximately 95 pages relating to the Miner's hospitalization for pneumonia in July 1997, as well as his subsequent diagnosis of lung cancer and his hospitalizations during his cancer treatment. In brief, these records establish that during the Miner's July 1997 hospitalization, a lung mass was discovered, and was determined to be cancerous. On March 22, 1998 the Miner was hospitalized due to shortness of breath, and remained in the hospital for several days. Dr. Eubank, the Miner's treating physician, noted the following in her Discharge Summary: "Bilateral decubitus films showed no evidence of shifting free fluid with extensive opacification of the left thorax, probably due to a combination of pulmonary parenchymal or pleural metastatic disease…" Dr. Eubank wrote the following, regarding her treatment plan: "I will further discuss treatment. I have discussed with him and his family, the fact that chemotherapy does not seem to be improving his condition and whether or not he wishes to continue is a point that we will re-discuss on Friday" (DX 19 at 17).

Also included are treatment notes, from the attending physician, Dr. Sandford Weiler, memorializing the Miner's final hospitalization and his death, in April 1998. The notes state that the Miner was admitted to the hospital on April 10, after being brought to the Emergency Room because he was dyspneic and had a smothering sensation that was not relieved by oxygen. In the Miner's history, the attending physician noted that "there has been a question of black lung." The medical Impressions at the Miner's hospital admission were as follows: 1) possible pneumonitis right [lung] base; 2) pulmonary edema; 3) CA [cancer] left lung, far advanced. His proposed treatment plan included providing oxygen by mask and increasing its concentration; prescribing antimicrobials; and administering Lasix intravenously for the Miner's pulmonary edema, and noted discharge "perhaps in three days." The next day, April 11, the Miner died. The attending physician's death summary, completed on April 29, stated that the Miner was in significant respiratory distress and "appeared terminal in the Emergency Room." The Miner was admitted to the hospital, and his condition deteriorated slowly but progressively over the remainder of the day. The family had indicated that resuscitation was not to be attempted in the

event of cardiac or respiratory arrest. The Miner stopped breathing and his heart stopped, less than 24 hours after his admission. Dr. Weiler listed the cause of death as a "combination of pneumonitis, pulmonary edema and carcinoma of the lung" (DX 19 at 2).

Medical treatment records from Holston Valley Medical Center (EX 3)

These records, consisting of approximately 15 pages, relate to the Miner's hospitalization and treatment in March 1998, shortly before his death. These records reflect that the Miner was admitted to the hospital on March 7, 1998, after showing a low-grade fever and shortness of breath. Pneumonia was suspected. A thoracentesis (removal of fluid from the lung) was performed, but it provided little relief. During this hospitalization, X-rays were taken showing that his lung cancer had progressed. The Miner and his family were informed about the disease's advancement, and they requested "Do Not Resuscitate" orders. Several reports from physicians are included in these treatment records. Among these is a consultation report by Dr. Robert A. Rosser, which listed the following Impressions: 1) advanced non-small cell carcinoma of the lung – status-post radiation and chemotherapy; 2) probably right lower lobe pneumonia; 3) multiloculated left pleural effusion; 4) probable significant airway obstruction on left – probably secondary to tumor; 5) hypoxemia; 6) history of black lung; 7) COPD with tobacco dependence. Dr. Rosser's recommendations included hospitalization with IV and antibiotic therapy, oxygen, hydration, and respiratory therapy. Dr. Rosser also remarked that he was not optimistic that a simple thoracentesis would suffice to help the Miner, and suspected pleurodesis (a more complicated procedure) would be required. He also noted: "It seems unlikely that chemotherapy alone will control the pleural process" (EX 3).

Discussion

The physician opinions discussed earlier, as well as the medical treatment records, all concur that the Miner's lung cancer was the principal cause of his death. As stated above, I have found that the Miner had pneumoconiosis, as defined in the regulation. However, the fact that the Miner had pneumoconiosis is insufficient, of itself, to establish that pneumoconiosis hastened his death. The regulation provides that the Claimant does not qualify for benefits if the principal cause of the Miner's death is a medical condition not related to pneumoconiosis, unless the Claimant establishes that pneumoconiosis is a substantially contributing cause of – that is, hastened – the Miner's death.

No medical professional has stated that the Miner's coal dust exposure was a cause of his lung cancer, and I find that no connection between the two has been established. However, Dr. Eubank has opined that the Miner's "black lung" contributed to his death. She also signed the death certificate, which listed "pneumoconioses" as a contributing cause of the Miner's death. The record contains no other medical opinion positing any causal connection between the Miner's pneumoconiosis and his death.

As I have discussed, Dr. Eubank's opinion that the Miner's pneumoconiosis contributed to his death is conclusory. It provides no information for me to assess whether Dr. Eubank's conclusion is founded upon medical evidence or any other reliable basis. In general, a death certificate, standing alone, is insufficient to establish that pneumoconiosis was the cause of a

Miner's death, particularly if there are no autopsy findings supporting the death certificate's conclusion. See Lango v. Director, OWCP, 104 F.3d 573 (3d Cir. 1997); Bill Branch Coal Co. v. Sparks, 213 F.3d 186 (4th Cir. 2000).

Indeed, although the record establishes that Dr. Eubank was the Miner's treating physician, it does not appear as though Dr. Eubank attended the Miner during his last hospitalization.[11] Notably, although the record establishes that Dr. Weiler, the attending physician who supervised the Miner's care during his final hospitalization, knew that the Miner had a Black Lung diagnosis, he did not mention the Miner's pneumoconiosis when he listed the causes of the Miner's death.

Additionally, the record establishes that the Miner's death, less than a year after his lung cancer diagnosis, was not unexpected by medical professionals. As the record reflects, Dr. Eubank, his treating physician, had concluded by March 1998 that chemotherapy was not providing good results, and he and his family established a "Do Not Resuscitate" order. The Miner's final respiratory crisis, which ended with his death, came just a few weeks later. The medical treatment records, prepared during and shortly after the Miner's last hospitalization, establish that pneumonia (pneumonitis) precipitated that final crisis. The records do not mention that pneumoconiosis caused that crisis or otherwise hastened his death.

Based on the foregoing, I must conclude that the Claimant has not established that the Miner's pneumoconiosis played any role in his death. Therefore, I find that the Claimant is unable to establish, by a preponderance of evidence that the Miner's death was due to pneumoconiosis.

IV. CONCLUSION

Based upon applicable law and my review of all of the evidence, I find that the Claimant has not established her entitlement to benefits under the Act.

V. ATTORNEY'S FEE

The award of an attorney's fee is permitted only in cases in which a Claimant is represented by counsel and is found to be entitled to benefits under the Act. Because benefits were not awarded in this Claim, the Act prohibits the charging of any fee to the Claimant for representation services rendered in pursuit of the Claim.

VI. ORDER

[11] Although the Claimant testified that Dr. Eubank was present at the Miner's death, Dr. Weiler wrote the treatment notes and death summary. The handwritten progress notes do not appear to be in Dr. Eubank's handwriting. See, e.g., DX 19 at 3, 4, 8, 12-14.

The Claimant's Claim for benefits under the Act is DENIED.

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Adele H. Odegard
Administrative Law Judge

Cherry Hill, New Jersey

NOTICE OF APPEAL RIGHTS: If you are dissatisfied with the administrative law judge's decision, you may file an appeal with the Benefits Review Board ("Board"). To be timely, your appeal must be filed with the Board within thirty (30) days from the date on which the administrative law judge's decision is filed with the district director's office. *See* 20 C.F.R. §§725.458 and 725.459. The address of the Board is: Benefits Review Board, U.S. Department of Labor, P.O. Box 37601, Washington, DC 20013-7601. Your appeal is considered filed on the date it is received in the Office of the Clerk of the Board, unless the appeal is sent by mail and the Board determines that the U.S. Postal Service postmark, or other reliable evidence establishing the mailing date, may be used. *See* 20 C.F.R. §802.207. Once an appeal is filed, all inquiries and correspondence should be directed to the Board.

After receipt of an appeal, the Board will issue a notice to all parties acknowledging receipt of the appeal and advising them as to any further action needed.

At the time you file an appeal with the Board, you must also send a copy of the appeal letter to Allen Feldman, Associate Solicitor, Black Lung and Longshore Legal Services, U.S. Department of Labor, 200 Constitution Ave., NW, Room N-2117, Washington, DC 20210. *See* 20 C.F.R. §725.481.

If an appeal is not timely filed with the Board, the administrative law judge's decision becomes the final order of the Secretary of Labor pursuant to 20 C.F.R. §725.479(a).